Maryland Department of Health and Mental Hygiene

Arboviral/Encephalitis/Aseptic Meningitis Surveillance Form

PATIENT INFORMATION **[or NEDSS ID# (if LHD completing form):_____]**

Last name: _____ First name: _____ MI: _____

Date of birth: _____/_____/_____ Age: _____ years / months / days Sex: Male / Female

Is patient Hispanic or Latino?

- 1. Yes
- 2. No
- 3. Unknown

RACE (Select one or more. If multiracial, select all that apply):

- 1. American Indian or Alaska Native
- 2. Asian
- 3. Black or African American
- 4. Native Hawaiian or other Pacific Islander
- 5. White
- 6. Unknown
- 7. Other

Street address: _____ City: _____

County: _____ State: ____ Zip Code: _____ Phone: _____

Occupation or Setting: _____ Occupation Zip Code: _____

CLINICAL INFORMATION

Date of onset: _____/_____/_____ **(required field)** Current diagnosis? _____

Hospitalized? Yes (Hospital:_____) / No

Date of hospital admission: _____/_____/_____ Date of discharge: _____/_____/_____

Was patient transferred to another hospital? Yes (hospital:_____) / No / Unknown

Outcome: Survived / Died / Unknown Date of death: ____/____/_____ Was autopsy performed? Yes / No / Unknown

LABORATORY INFORMATION

Was enteroviral testing requested? Yes / No / Unknown Was arboviral testing requested? Yes / No / Unknown

Date Collected	Date Reported	Laboratory	Test Type	Specimen	Result

Please complete the following only if patient has preliminary positive arboviral result:

ADDITIONAL CLINICAL INFORMATION

Acute Flaccid Paralysis	Yes / No / Unknown	Myalgia	Yes / No / Unknown
Fever (≥38°C or 100°F)	Yes / No / Unknown	Arthralgia	Yes / No / Unknown
Headache	Yes / No / Unknown	Arthritis	Yes / No / Unknown
Stiff neck	Yes / No / Unknown	Paresis/Paralysis	Yes / No / Unknown
Rash	Yes / No / Unknown	Altered Mental Status	Yes / No / Unknown
Nausea/Vomiting	Yes / No / Unknown	Seizures	Yes / No / Unknown
Diarrhea	Yes / No / Unknown		
Other symptoms	Yes (specify: _____) / No / Unknown		

RISK FACTOR INFORMATION

Has patient traveled outside Maryland in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where: _____

Has patient had known mosquito bite(s) in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where (geographic location): _____

Has patient spent extended time outdoors in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify when and where: _____

Has patient received transplant or blood product transfusions in the 1 month prior to onset? Yes / No / Unknown

If yes, specify: _____

Has patient donated blood products in the 2 weeks prior to onset? Yes / No / Unknown

If yes, specify: _____

Is patient pregnant or breastfeeding? Yes / No / Unknown / Not Applicable Weeks pregnant ____ Due date _____

Does patient have household or travel contacts with similar illness? Yes / No / Unknown

If yes, specify:_____

VACCINE INFORMATION

Has patient received yellow fever (YF) vaccine? Yes (Date: ____/____/_____) No / Unknown

Has patient received Japanese encephalitis (JE) vaccine? Yes (Date: ____/____/_____) No / Unknown

Has patient received Central European encephalitis (CEE) vaccine? Yes (Date: ____/____/_____) No / Unknown

REPORTING SOURCE

Name:_____ Affiliation: _____

Title: ICP / Resident / Attending / Other_____ Work address:_____

City:_____ State:_____ Zip Code:_____ Phone: _____